

TRICARE Data Quality Course

Current & Future Prospective Payment System

The Quadruple Aim: Working Together, Achieving Success

Program Review and Evaluation

January 2012



OSD(Health Affairs); Health Budgets & Financial Policy

Resourcing the Direct Care System for Value



The Direct Care System (DCS) is the heart of military medicine and provides:

- a ready to deploy medical capability
- a medically ready force
- delivery of the health benefit to warriors and their families

..but at the appropriate value?

Outputs (Activities) + Outcomes (Readiness,
Population Health) + Customer satisfaction

Resources (MilPers, appropriations, reimbursements)

Creating Breakthrough Performance in the MHS



Agenda



- Current Prospective Payment System
- Future Prospective Payment System??
 - Performance Based Planning Pilots
- Issues to consider for Data Quality

Background



- PPS initiated in 2005 to rationalize the direct care budget adjustments
 - Provide funds for recapture
 - Budget to follow performance
- Initially proposed as a capitated system
 - Considered too risky and too large a leap
 - Fee for service (FFS) system seen as simpler to implement and necessary to familiarize the staff with workload measures
 - SMMAC decided to start as a Fee for Service system with capitation some time in the future

Background (cont.)



- While calculations in PPS are done at the MTF level, HA/TMA adjustments are just to the Services
 - Each Service has its own methodology for allocating to the MTFs
 - Some aspects of PPS are involved in these methodologies
- Most medical personnel are now familiar with workload measurement (RVUs, RWPs)

PPS Value of Care



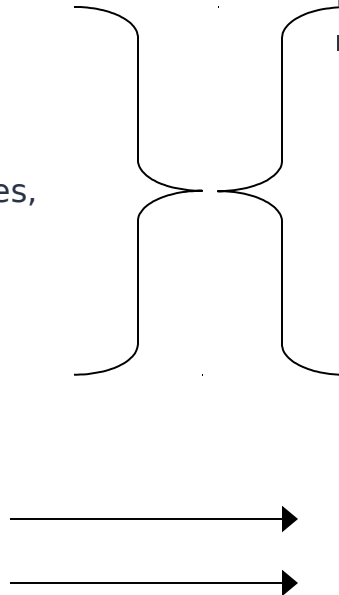
- Value of MTF Workload
 - Fee for Service rate for workload produced
- Rates based on price at which care can be purchased
 - TMAC rates
 - Not MTF costs
- Computed at MTF level but allocated to services
 - Rolled up to Services

TMAC versus PPS



Civilian

- Inpatient
 - Institutional
 - Hospital (MS-DRG)
 - Including ancillaries, pharmacy
 - Professional (RVU)
 - Surgeon
 - Anesthesiologist
 - Rounds
 - Consultants
- Outpatient
 - Professional (RVU)
 - Institutional (APC)
- Outpatient Ancillary
 - (RVU/Fee Schedule)



Direct Care PPS

- Inpatient (RWP, i.e. MS-DRG)
 - All Institutional and Professional
 - Hospital
 - Including ancillaries, pharmacy
 - Surgeon
 - Anesthesiologist
 - Internist
 - Consultants
- Outpatient
 - Professional (RVU)
 - Institutional (APC)
 - Emergency Room and Same Day Surgery
- Outpatient Ancillary (Pass Thru)
 - None

- Has FFS PPS outlived its usefulness?
 - Concern that FFS induces:
 - Over-utilization
 - Upcoding
 - Treatment over prevention
 - Considerable discussion each year on mid-year adjustments
 - Competition/rancor between services
 - MTFs strong focus only on PPS earning areas



Future Prospective Payment System??

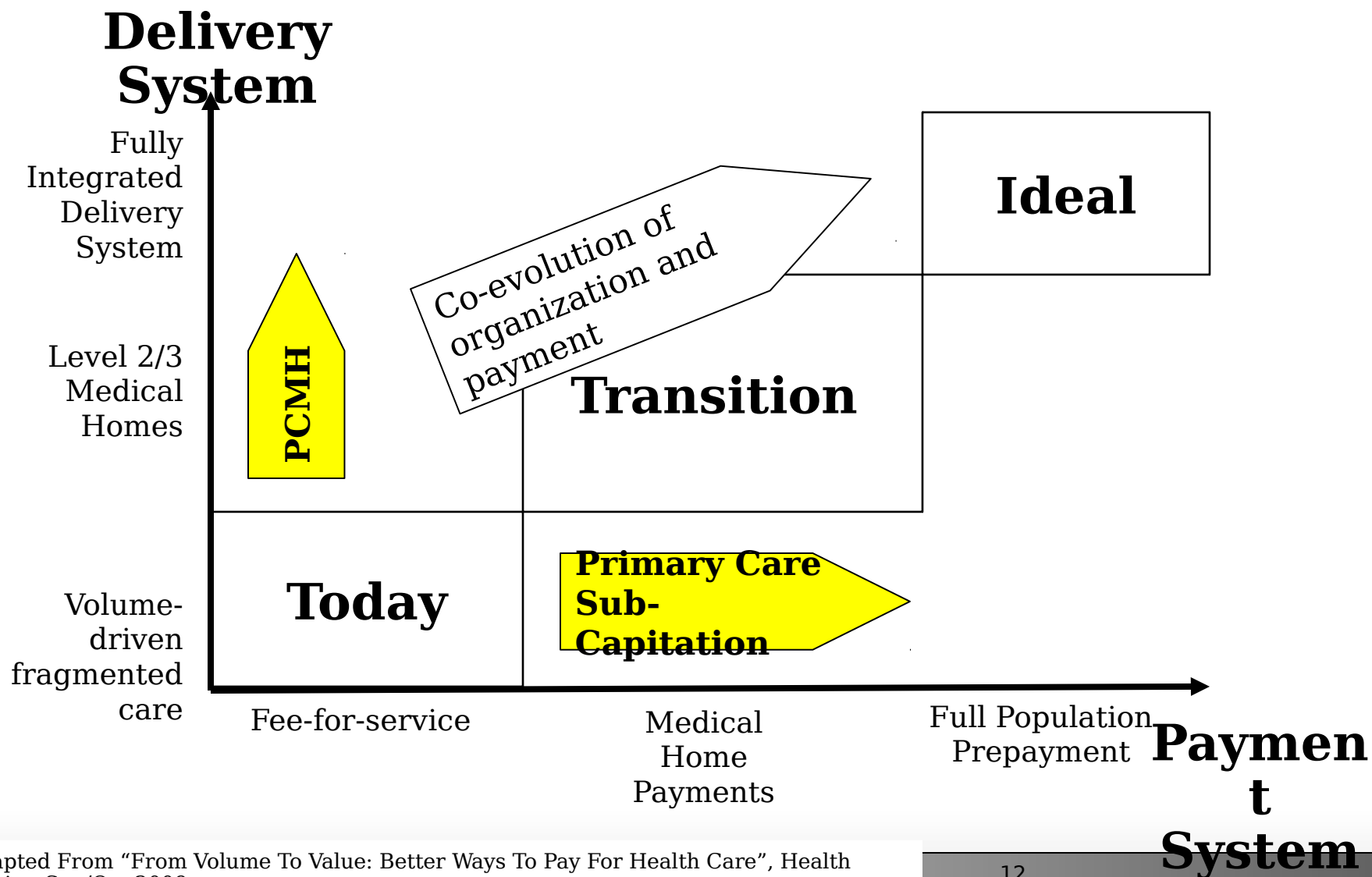
Performance-Based Planning

Expanding Pay for Performance to Match the Vision



- Premise: MHS Value is predicated on three elements
 - Outputs - the volume of work that we accomplish, measured currently by RVUs/APCs and RWPs/Bed Days
 - Incomplete
 - Outcomes - often measured via factors such as HEDIS/JCAHO
 - Customer Satisfaction
- Our focus to date has been centered on productivity (Outputs) as the MHS source of value for the Department.
- Goal: Create a financial mechanism for the direct care system that will emphasize value measures for outcomes and customer satisfaction in a balanced fashion with outputs

Transition In Both Payment & Delivery Systems

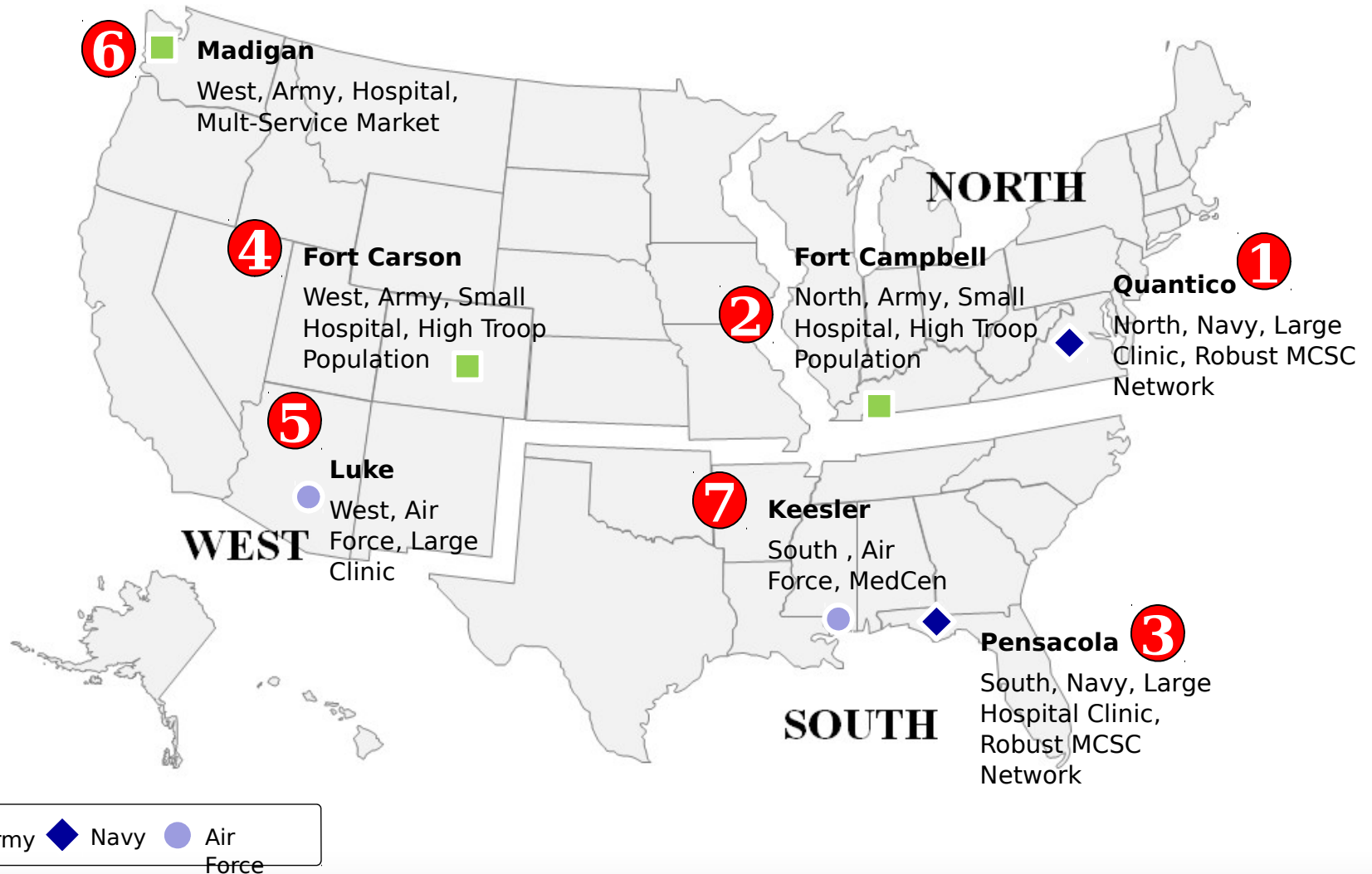


Performance Planning Integrated Project Team



- The Joint Health Operations Council (JHOC) chartered a Performance Planning Integrated Project Team (IPT)
 - Create a revised incentive structure and planning approach aligned with the Quadruple Aim
 - Readiness/Population Health/Experience of Care/Per Capita Cost
 - The approach encompasses the total beneficiary population
 - Direct and Purchased
 - Prime, Standard
 - Piloted at seven sites in 2010.

Pilot Sites



Incentive structure

Readiness, Pop Health, Experience of Care



AIM	ATTRIBUTES
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Readiness	Indeterminate Rate - TBD
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Population Health - Prevention	Mammography
	Colorectal
	Cervical

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Experience of Care- Evidence Based Guidelines	Diabetes A1c Sreening
	Diabetes LDL < 100mg/dL
	Diabetes A1c > 9
	ORYX AMI - Aspirin at discharge
	ORYX AMI - Beta blocker at discharge
	ORYX CAC - HMPC Document
	ORYX HF - Discharge
	ORYX PN - Antibiotic received
	ORYX PN - Vaccination
	ORYX SCIP - Inf1a Antibiotic overall
	ORYX SCIP - Inf3A Antibiotic dc

AIM	ATTRIBUTES
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Experi ence of Care- Beneficia ry Satisfact ion	Satisfied with health care during visit
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Experi ence of Care- PCM Continui ty	Continuity
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Experi ence of Care- Access	3rd Avail Apt (Routine)
	3rd Avail Apt (Acute)

Incentive structure

Per Capita Cost



AIM	ATTRIBUTES
Management of ER Utilization	Enrollee Utilization of ER Services
Primary Care RVUs considered under PCMH capitation rate	Primary Care RVUs, primary care RVUs generated under the PCMH primary care capitation definition; RVUs for "preventive services" are excluded
Primary Care Fee for Service, Non-Capitated	Primary Care RVUs, Non-Cap total RVUs generated from primary care services not falling under the capitation definition;
Specialty Care Fee for Service	Specialty Care RVUs total number of RVUs from specialty care; RVUs for "preventive services" are excluded
Outpatient Facility Fee for Service	Ambulatory Payment Classification (APCs) (facility fee for ER and ambulatory surgical services)

AIM	ATTRIBUTES
Inpatient Fee for Service (non-mental health)	RWPs
Inpatient Fee for Service for Mental Health	Mental Health Bed days
Dental Fee for Service	Dental Weighted Values - TBD
PMPM Management	PMPM Management PMPM % Increase annually

Incentive structure

Per Capita Cost, cont



AIM	ATTRIBUTES
Total Prime Enrollees	Enrollment
Total PCMH Enrollees	PCMH enrollees (could be new or current prime enrollees). NOTE: this provides a target for total PCMH enrollment; it is not the year to year difference.
RVUs per PCMH Enrollee	Primary care RVUs produced at the MTF for PCMH enrollee
Leaked RVUs per PCMH Enrollee	Primary care RVUs NOT produced at the MTF for PCMH enrollees
Total Net Reward for PCMH Enrollees	Final capitated value

Additional rewards given for

> Balanced bonus: % of measures improving

> Care management: \$/enrollee (higher \$ for PCMH enrollees) for overall mgn

How to Succeed



- Current Prospective Payment System (fee for service)
 - Maximize workload
 - Recapture private sector care
 - Optimize coding
 - Complete records
 - Improve productivity
 - Maximize patient visits
 - Fee for Service rate for workload produced
- Pilots – Follow Quadruple Aim
 - Readiness (TBD)
 - Experience of care
 - Population Health
 - Per Capita Cost

How to Succeed



- Current Prospective Payment System (fee for service)

- Maximize workload
 - Recapture private sector care
 - Optimize coding
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 - Improve productivity
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- Fee for Service rate for workload produced

- Pilots – Follow Quadruple Aim

- Readiness (TBD)
- Experience of care
- Population Health
- Per Capita Cost

How to Succeed, cont



- Experience of Care
 - Satisfied customer
 - Timely access
 - PCMs treat own patients
 - Follow clinical guidelines

- Population Health
 - Follow preventive screening protocols



How to Succeed, cont

■ Per capita cost

– Effective management of enrollees

- Manage utilization
- Provide care at appropriate location
 - Minimize ER use

*PMPM
& ER*

– Effective use of MTF & staff

- Increase productivity
- Recapture private sector care

*Productivity (RVUs,
RWPs &
APGs)*

– Effective management of PCMH enrollees

- Use of non-visit touches
- Efficient use of support staff
- Optimize enrollment ratios
- Comprehensive care coordination

*PCMH &
Capitation*



Performance Planning Site Results

	Madigan	Carson	Campbell	Pensacola	Quantico	Keesler	Luke	Total
Measure								
HEDIS	1,241,385	766,130	655,038	198,465	18,535	410,630	73,568	3,363,750
ORYX	3,600	6,400	39,067	1,067	-	8,400	-	58,533
Satisfaction	45,853	23,918	947	217,245	140,037	5,293	11,643	444,936
Continuity	317,475	(103,308)	(669,354)	76,620	(256,518)	(296,403)	(57,495)	(988,983)
Access	(360,456)	224,161	(526,867)	(179,494)	(187,297)	33,775	(238,878)	(1,235,055)
ER Rate	38,822	44,255	(124,499)	(30,535)	(10,820)	6,229	(11,098)	(87,645)
Workload	(2,883,587)	22,236,590	827,262	(75,277)	1,455,457	7,981,994	2,117,533	31,659,972
PMPM	(4,687,038)	(784,784)	(9,056,840)	-	(668,717)	995,769	235,425	(13,966,185)
Care Management	2,995,705	1,864,985	1,973,943	1,308,735	698,380	686,353	794,238	10,322,338
Total	(3,288,240)	24,278,346	(6,881,303)	1,516,826	1,189,058	9,832,039	2,924,936	29,571,661
Balance	-	102,088	-	31,842	-	92,502	16,148	242,580
Adjustment	(3,288,240)	24,380,434	(6,881,303)	1,548,668	1,189,058	9,924,541	2,941,084	29,814,242
Hold Harmless	(2,883,587)	24,380,434	827,262	1,548,668	1,455,457	9,924,541	2,941,084	38,193,859

Observations:

- HEDIS and Workload are for the most part positive reflecting previous incentives.
- Satisfaction generally positive.
- Continuity and access results are mixed.
- PMPM for the most part is negative reflecting higher than targeted per capita costs.

Performance Planning Pilots



- Service Level adjustments
- Difference between Standard PPS earning and Performance adjustments
 - Includes Hold Harmless for this year
 - Numbers would be lower for two Services if hold harmless provision was not in effect

		Army	Navy	Air Force
Standard PPS Earnings		\$ 20,180,265	\$ 1,380,180	\$ 10,099,528
Performance Planning Earnings		\$ 21,947,156	\$ 2,836,095	\$ 12,748,303
		\$ 1,766,891	\$ 1,455,916	\$ 2,648,775
Difference		\$ 1,766,891	\$ 1,455,915	\$ 2,648,775
If no hold harmless Provision		(6,341,254)	1,183,766	2,648,775

Way Forward for Performance Planning



- Build off existing work - refine and strengthen current MTF Performance Plans for FY12; due to TMA 1 Sep
 - “Closing the Gaps” - Initiative selection should be based on under performing measures, not consistently successful measures
- Access to data key for MTFs to close gaps; MTF scorecards will be available 1 Oct
- Test primary care sub-capitation for approved sites 1 Oct
 - 4th Level MEPRS implementation for these sites needs to be completed by 1 Aug
- Incentivize MTF leadership to fully engage in

Issues to Consider



- All MTFs need to Ensure Timely data submission
- Professional Services
 - Professional services should be coded for Inpatient
 - Accurate coding
 - Ensure proper coding for care including Units of Service
 - Need to ensure coding matches documentation
 - Eventually audit adjustments to claims
- Treatment of Enrollees
 - Quality payments will rely on accurate identification of Enrollees
 - Documentation of treatment for Preventive Services
- Workload Trending
 - CMS changes to weights can cause misleading trends
 - Budget Neutrality Factor used for CY06 and earlier
 - CY10 removal of weights for Consult codes
 - CMS stopped paying, but increased E&M codes
 - MHS zero weight for consult codes in CY11
 - CY11 significant increase in Practice Expense RVUs
 - CMS Conversion factor decreases by over 10%



Back-up



Contact Information:

BACK UP SLIDES

IME Factors



DMIS	Name	FY02	FY03	FY04	FY05	FY06	FY07	FY09	FY10	FY11
0014	DAVID GRANT	1.4141	1.3765	1.5737	1.5996	1.6313	1.5676	1.3485	1.2930	1.2155
0024	PENDLETON	1.2895	1.1860	1.1681	1.1848	1.1828	1.1739	1.1304	1.1476	1.1256
0029	SAN DIEGO	1.6415	1.5067	1.5067	1.5173	1.4929	1.4588	1.4554	1.5370	1.5226
0037	WALTER REED	1.5849	1.5175	1.5265	1.5523	1.5368	1.5824	1.5061	1.6961	1.7415
0038	PENSACOLA	1.2692	1.2269	1.2269	1.2302	1.1938	1.1713	1.2092	1.2045	1.1894
0039	JACKSONVILLE	1.3484	1.2954	1.2911	1.2944	1.2866	1.2669	1.2690	1.2086	1.3290
0042	EGLIN	1.2544	1.2801	1.3120	1.3202	1.2622	1.1859	1.1928	1.2346	1.2346
0047	EISENHOWER	1.2772	1.2216	1.2208	1.2318	1.2096	1.2352	1.2031	1.2249	1.2746
0048	MARTIN	1.2230	1.1733	1.1462	1.1547	1.1477	1.1422	1.1408	1.1498	1.1519
0052	TRIPLER	1.3792	1.3249	1.3319	1.3482	1.3987	1.3813	1.4400	1.4859	1.4607
0055	SCOTT	1.3377	1.2983	1.3119	1.3034	1.2689	1.2554	1.0000	1.0000	1.0000
0066	MALCOLM GROW	1.3646	1.3306	1.3898	1.4492	1.4366	1.4199	1.3663	1.2949	1.0000
0067	BETHESDA	1.6914	1.5430	1.5413	1.4705	1.4139	1.3984	1.3493	1.3882	1.3384
0073	KEESLER	1.4844	1.3613	1.2533	1.4352	1.4806	1.0000	1.0737	1.0737	1.1410
0078	EHRLING BERGQUIST	1.3313	1.3286	1.3961	1.5929	1.3220	1.0000	1.0000	1.0000	1.0000
0086	KELLER	1.0114	1.0309	1.0417	1.0398	1.0394	1.0372	1.0379	1.0394	1.0394
0089	WOMACK	1.1396	1.1176	1.1254	1.1259	1.1187	1.1460	1.1425	1.1471	1.1277
0091	LEJEUNE	1.0000	1.0000	1.0000	1.0621	1.0604	1.0976	1.0637	1.0548	1.0557
0095	WRIGHT-PATTERSON	1.6438	1.6523	1.7406	1.6789	1.6153	1.5976	1.3764	1.4453	1.4453
0108	WILLIAM BEAUMONT	1.2425	1.1995	1.1971	1.2033	1.2267	1.2041	1.2129	1.2461	1.2665
0109	BROOKE	1.5289	1.4459	1.4553	1.4776	1.4565	1.4353	1.4474	1.5329	1.4864
0110	DARNALL	1.1182	1.0996	1.0996	1.1035	1.0977	1.0914	1.0987	1.0932	1.0932
0117	WILFORD HALL	1.5818	1.4904	1.6006	1.6300	1.5887	1.5694	1.5887	1.6467	1.6562
0123	DEWITT	1.2275	1.1883	1.1883	1.1942	1.1920	1.2071	1.1974	1.2011	1.2062
0124	PORTSMOUTH	1.3389	1.3066	1.3066	1.3216	1.3126	1.3005	1.2684	1.3324	1.3334
0125	MADIGAN	1.6389	1.5363	1.5630	1.5438	1.4788	1.4499	1.4534	1.4947	1.4698
0126	BREMERTON	1.1716	1.1701	1.1817	1.1902	1.2009	1.1977	1.1858	1.1783	1.1873

Value of 1.0 is used if there is no IME to zero out calculation.

Primary Care Capitation



- Determine historical Primary Care Capitation Rate
 - Apply appropriate logic for MHS workload
 - To include
 - Code Sets
 - Clinic/Provider restrictions
 - Ensure that rate includes all care for enrollees
 - Direct Same MTF/Direct Other MTF/Purchased Care
 - Divide total workload (DC/PSC) by enrollees to get historical PC capitation rate (utilization rate) at that MTF
- In evaluation year, for MHP enrollees
 - Ignore actual primary care workload for MHP enrollees
 - Substitute historical utilization rate after subtracting PSC utilization for MHP enrollees
- Effect: If utilization is contained, MTF will still get workload credit as if utilization stayed elevated
 - If workload can be recaptured from PSC, MTF workload credit could increase with no actual increase in workload

HEDIS Preventive Services



- Adherence to HEDIS Guidelines
 - Breast Cancer Screening
 - Cervical Cancer Screening
 - Colorectal Screening
 - Diabetes A1c Screen
 - Asthma Meds
 - Diabetes A1c < 9
 - Diabetes LDL < 100

DRG Comparison



- Historical DRG
 - System to classify hospital cases into one of approximately 500 groups
 - System in use since approximately 1983, with minor updates on a yearly basis
 - Calculated for TRICARE using CMS method just for our beneficiaries with-in Purchased Care claims

- MS-DRG – Severity Adjusted DRGs
 - System used to differentiate levels of complexity for the DRGs
 - Approximately 750 different groups
 - CMS implemented in 2008
 - TRICARE implemented in 2009

RVU comparison



- Old Method
 - Uses Work RVU for all payments
 - Work RVU only represents provider portion
 - Payments based on Product Lines
 - Defined by MEPRS codes
 - Significant variation in rates (\$38/RVU to \$330/RVU)
 - Rates based on Allowed Amount from Purchased Care claims divided by Work RVUs
- New Total RVU method
 - Uses both Work and Practice RVUs for payments
 - Practice RVU represents the cost of the staff/office/equipment
 - Includes Units of Service adjustments for both RVUs
 - Provides appropriate credit for equipment intensive procedures
 - Allows for a Standard Rate per RVU
 - Can use same rate as Purchase Care
 - Used with Ambulatory Payment Classification (APCs)
 - Facility charges now available for ER and Same Day Surgery

Geographic Practice Cost Index (GPCI)



- Based on Medicare locality Adjustments
- Different rates for Work and Non-Facility Practice
 - Work
 - Generally 1.0 +, max 1.5 for Alaska
 - Non-Facility Practice
 - Range 0.803 (part of Missouri) to 1.342 (part of California)
- Payment Amount
 - Multiply the RVU for each component times the GPCI for that component

Expansion of PPS for External Workload



- Valuation to began in FY2008
 - All reporting will be considered “new” workload
 - Standardized reporting method across Services
- External Partnerships (5400) and VA facilities (2000)
 - Differentiate Professional Service vs Facility Charges
- Payment based on Total RVU
 - Enhanced (Work + Facility Practice)
 - Standard Rate similar to CMS
 - Not Product Line specific – FY10 same as all RVUs
 - Professional Providers only
 - MEPRS A & B codes only
- Still must solve DoD Circuit Rider workload reporting

Current PPS Workload



- Inpatient – MEPRS A Workcenters
 - Non-Mental Health – Severity Adjusted DRGs
Relative Weighted Products (MS-RWPs)
 - Mental Health - Bed Days

- Outpatient – MEPRS B Workcenters
 - Provider Aggregate Enhanced Work + Practice
Relative Value Units (RVUs)
 - Excluding Generic Providers
 - Ambulatory Payment Classification (APCs)
 - Facility charges now available for Emergency Room (ER) and Same Day Surgery (SDS)
 - Consistent with TRICARE change for CY09



Changes in RVU

- Provider Affected (PA) Changes:
 - ❖ Nurse Crediting (no credit for procedures Skill Type 3 and 4 cannot perform; e.g., Physician E&M codes, Shunt procedures, etc.)
 - ❖ Multiple Provider Discounting (1st and 2nd provider are always credited, although sometimes the 2nd is only at 20%, 3rd provider never credited)
 - ❖ Multiple procedure discounting
 - ❖ Modifier impact (e.g., increase for bilaterals; decrease for procedure stopped before completion)
 - ❖ SADR used 1st modifier; CAPER uses both
 - ❖ Procedure clean-up (e.g., brain lesion on a telcon, credit for the telcon not the brain lesion; same for follow-up, credit for the follow-up not the procedure; E&M and procedure, E&M only counted if mod 25 is used)

Changes in RVU



- CAPER: no credit for (SADR got credit)
 - ✓ J - Rx administered in doctor's office, Rx already pays for it
 - ✓ K - orthotics, lab already paid for elsewhere
 - ✓ L - splints, shoe inserts, etc., already paid for elsewhere



Facility / Non-Facility Flag

- Indicates whether the care was provided in a facility or non-facility setting
 - F = Facility (MEPRS A, MEPRS BIA, MEPRS B**5/7, 0124 B**6, specific CPT (cardiac cath, etc)
 - N = Non-Facility (all others)
 - R = Resource Sharing, VA
- Uses: computation of Practice Expense RVU, PPS

Weight Changes Adjustments



- Previous adjustments for weight/coding changes between CY09/10
 - Overall adjustment for weight changes
- Service Specific adjustment for Consult codes not being Budget Neutral in Direct Care
 - Affects FY10 and out, compared to FY09
- CY11 Significant change in Practice Expense RVUs
 - Caused Conversion factor to decrease by almost 10%

GWOT Workload



- Already paid for under OCO funding
 - Significant workload changes pre/post deployment not part of traditional health care benefit delivery
 - Exaggerates workload reporting changes
 - Removed in years prior to last year
- Remove GWOT workload from workload accounting based on Diagnostic codes
 - V70.5_4 Pre-Deployment Related encounter
 - V70.5_5 Intra-Deployment encounter
 - V70.5_6 Post-deployment related encounter
 - V70.5_D Pre-Deployment Assessment
 - V70.5_E Initial Post-Deployment Assessment
 - V70.5_F Post Deployment Health Reassessment (PDHRA)
 - V70.5_G Global War on Terrorism (GWOT)
- Can be accounted for in Re-Baseline

Valuing MHS Workload

Fee for Service Rates FY12



- Value per MS-RWP - \$8,688 (MEPRS A codes)
 - Average amount allowed
 - Including institutional and professional fees
 - Excluding Mental Health (MH)/Substance Abuse (SA)
 - Adjusted for local Wage index and Indirect Medical Education Adjustment

- Value per Mental Health Bed Day - \$803 (MEPRS A codes)
 - Average amount allowed
 - Including institutional and professional fees
 - Adjusted for local Wage index and Indirect Medical Education Adjustment

- Value per RVU - \$33.97 (MEPRS B codes)
 - Standard Rate - like TMAC/CMS
 - Excluding Ancillary, Home Health, Facility Charges
 - Adjusted for local geographic price index both Work and Practice

- Value per APC - \$69.61 (Facility records)
 - Standard Rate